TEXAS DEPARTMENT OF INSURANCE
**Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)**
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# MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

## *GENERAL INFORMATION*

**Requestor Name**
Steven W. Michelsen, D.O.

**Respondent Name**
New Hampshire Insurance Company

**MFDR Tracking Number**
M4-16-3595-01

**Carrier's Austin Representative**
Box Number 19

**MFDR Date Received**
August 2, 2016

## *REQUESTOR'S POSITION SUMMARY*

**Requestor's Position Summary:** "We are requesting payment in full plus interest at this time due to the fact that this was a clean claim."

**Amount in Dispute:** $15.00

## *RESPONDENT'S POSITION SUMMARY*

**Respondent's Position Summary:** Division Note: The Division placed a copy of the Medical Fee Dispute Resolution request in the insurance carrier's Austin representative box, which was acknowledged as received on August 10, 2016. 28 Texas Administrative Code §133.307(d)(1) requires that:

> The response will be deemed timely if received by the division via mail service, personal delivery, or facsimile within 14 calendar days after the date the respondent received the copy of the requestor's dispute. If the division does not receive the response information within 14 calendar days of the dispute notification, then the division may base its decision on the available information.

The insurance carrier did not submit a response for consideration in this dispute. Accordingly, this decision is based on the information available at the time of review.

## *SUMMARY OF FINDINGS*

| Dates of Service | Disputed Services | Amount In Dispute | Amount Due |
|---|---|---|---|
| May 9, 2016 | Work Status Report | $15.00 | $15.00 |

## *FINDINGS AND DECISION*

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

**Background**

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.

2. 28 Texas Administrative Code §133.10 sets out the requirements for medical bills.
3. 28 Texas Administrative Code §129.5 sets out the procedures for work status reports.
4. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 14 – Diagnosis was invalid for the date(s) of service reported.
   - 18 – Duplicate claim/service.

**Issues**

1. Is the insurance carrier's reason for denial of payment supported?
2. Is the requestor entitled to reimbursement for the disputed service?

**Findings**

1. The requestor is seeking reimbursement for completing a Texas Workers' Compensation Work Status Report (DWC073). The insurance carrier denied disputed services with claim adjustment reason code 14 – "DIAGNOSIS WAS INVALID FOR THE DATE(S) OF SERVICE REPORTED." 28 Texas Administrative Code §133.10 states that a "diagnosis or nature of injury (CMS-1500/field 21) is required, at least one diagnosis code and the applicable ICD indicator must be present."

   Review of the submitted information finds that the CMS-1500, field 21 includes ICD-10 code S46.012A. The division finds that this was a valid code, effective for the date of service in question. The insurance carrier's denial reason is not supported. The disputed services will therefore be reviewed per applicable Division rules and fee guidelines.

2. 28 Texas Administrative Code §129.5(i) states:

   > Notwithstanding any other provision of this title, a doctor may bill for, and a carrier shall reimburse, filing a complete Work Status Report required under this section or for providing a subsequent copy of a Work Status Report which was previously filed because the carrier, its agent, or the employer through its carrier, asks for an extra copy. The amount of reimbursement shall be $15. A doctor shall not bill in excess of $15 and shall not bill or be entitled to reimbursement for a Work Status Report which is not reimbursable under this section…

   The requestor submitted a copy of a DWC073, dated May 9, 2016, to support that services were rendered as billed. Therefore, the total allowable for the disputed service is $15.00. The insurance carrier paid $0.00. A reimbursement of $15.00 is recommended.

**Conclusion**

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $15.00.

***ORDER***

Based on the submitted information, pursuant to Texas Labor Code Sec. 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services in dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $15.00, plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

**Authorized Signature**

| | Laurie Garnes | October 7, 2016 |
|---|---|---|
| Signature | Medical Fee Dispute Resolution Officer | Date |

## *YOUR RIGHT TO APPEAL*

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, 37 *Texas Register* 3833, applicable to disputes filed on or after June 1, 2012.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

**Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812**.